MRC RELEASE OF INFORMATION FOR DDRS

State Form 51686 (R / 12-05) / BQIS 0010

FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF DISABILITY AND REHABILITATION SERVICES
DIVISION OF AGING MORTALITY REVIEW COMMITEE

PURPOSE: This form is used to confirm the direction of an individual that Provider use or disclose the individual's protected health information for a particular purpose.

SECTION A: PSYCHOTHERAPY NOTES

☐ Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information. *(Please make a separate copy to utilize for psychotherapy notes prior to using this form.)*

SECTION B: THE INDIVIDUAL *(OR THE INDIVIDUAL'S PERSONAL REPRESENTATIVE)* CONFIRMING THE AUTHORIZATION

I authorize the use and/or disclosure of my protected health information as described in Section C below. I understand this authorization is voluntary and made to confirm my direction.

I understand that, if the persons or organizations I authorize below to receive and/or use the protected health information described below are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Name of individual	Social Security number

Address *(number and street, city, state, ZIP code)*

Telephone number	E-mail address	Subscriber number
( )		

SECTION C: THE USE AND/OR DISCLOSURE BEING AUTHORIZED

PROTECTED HEALTH INFORMATION TO BE USE AND/OR DISCLOSED: Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed *(if this authorization is for psychotherapy notes, no other type of protected health information may be listed on this authorization).*

ENTITIES AUTHORIZED TO USE OR DISCLOSE: Name or specifically identify the persons or organizations *(or the classes of persons and/or organizations),* including Provider, who you are authorizing to make use of and/or to disclose the protected health information described above.

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SECTION D: EXPIRATION AND REVOCATION

EXPIRATION: This authorization will expire *(complete one)*

☐ On _____
(month, day, year)

☐ On occurrence of the following event *(which must relate to the individual or to the purpose of the use and/or disclosure being authorized)*

SECTION D: EXPIRATION AND REVOCATION *(continued)*

RIGHT TO REVOKE: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Name of contact		
Address *(number and street, city, state, ZIP code)*		
Telephone number ( )	Fax number ( )	E-mail address

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to the Provider. I understand that, by signing this form, I am confirming my authorization that the Provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature of individual or personal representative	Date (month, day, year)

If this authorization is signed by an individual's personal representative on behalf of the individual, complete the following.

Name of personal representative	Relationship to individual

If preferred, information can be released directly to :
Mortality Review Committee Attn: Lynn Underwood; 402 W Washington St; PO Box 7083, MS26; IGCS - Room W451; Indianapolis, IN 46207-7083; Telephone number (317) 234-3665; Fax number (317) 234-2225

If multiple release forms are necessary, this form may be copied.